

**Report of the Continuity of Care Advisory Panel**

**January 21, 2014**

## Table of Contents

<b>Advisory Panel Membership</b> .....	4
<b>Message from the Advisory Panel Chair</b> .....	5
<b>Introduction</b> .....	6
<i>Charge to the Advisory Panel</i> .....	6
<i>Process</i> .....	7
<b>I. ACCESSIBILITY OF MENTAL HEALTH RECORDS</b> .....	9
A. Federal and State Privacy Laws .....	9
B. Health Information Exchange.....	9
C. Electronic Health Record Utilization .....	10
<b>II. SERVICES TO ADDRESS THE NEEDS OF INDIVIDUALS WITH SERIOUS MENTAL ILLNESS</b> .....	11
<b>III. WORKFORCE TRAINING</b> .....	11
<b>IV. MENTAL HEALTH LITERACY</b> .....	12
<b>V. AREAS THAT NEED ADDITIONAL RESEARCH</b> .....	13
A. Addressing the Behavioral Health Provider Workforce Shortage .....	13
B. Expansion of Telemedicine .....	13
C. Addressing Language Barriers in Health Care Settings .....	14
D. Additional Areas for Future Research.....	14
<b>VI. DELEGATED DECISIONMAKING</b> .....	15
A. Surrogates .....	15
B. Guardianship.....	16
C. Advance Directive for Mental Health .....	17
<b>VII. SERVICES FOR COURT-INVOLVED INDIVIDUALS</b> .....	18
A. Clinical Review Panels.....	18
B. Community-Based Forensic Services.....	19
<b>VIII. INVOLUNTARY COMMITMENT</b> .....	19
A. Dangerousness Standard.....	20
B. Outpatient Civil Commitment .....	21
<b>Appendix 1 – Recommendations to Refer to Other State Entities</b> .....	23
<b>Appendix 2 - Existing DHMH Programs and Efforts</b> .....	25

<b>Appendix 3 – Health Professional Shortage Areas .....</b>	<b>26</b>
<b>Appendix 4 - History of Involuntary Civil Commitment, Erik Roskes, MD. ....</b>	<b>31</b>
<b>Sources .....</b>	<b>34</b>

## **Advisory Panel Membership**

### ***Chair of the Advisory Panel***

**Dr. Gayle Jordan-Randolph**, Deputy Secretary for Behavioral Health and Disabilities,  
Department of Health and Mental Hygiene

### ***Members***

**Clarissa E. Netter**, Senior Consultant, Mainstream Recovery Consultants

**Dr. Stephen B. Goldberg**, Chief Operating Officer, Conmed Healthcare Management

**Dr. John Boronow**, Medical Director for Adult Services, Sheppard Pratt Hospital

**Margaret R. Garrett**, Senior Counsel, The Johns Hopkins Health System Corporation

**Dr. Anita Smith Everett**, Section Chief, Johns Hopkins Bayview Community and General  
Psychiatry

**Dr. Randell Nero**, Director of the Patuxent Institution, Department of Public Safety and  
Correctional Services

## **Message from the Advisory Panel Chair**

Serious mental illness is a term that includes conditions such as schizophrenia, bipolar disorder, and major depression. Studies have shown that interruptions in treatment for individuals with serious mental illness can delay recovery, and that, in rare instances can contribute to dangerous behavior. Given these findings, the Department of Health and Mental Hygiene convened the Continuity of Care Advisory Panel to explore ways to improve continuity of care for individuals with serious mental illness.

In total, the Advisory Panel offers 25 recommendations to address deficiencies in continuity of care in the following areas: (1) accessibility of mental health records; (2) services to address the needs of individuals with serious mental illness; (3) workforce training; (4) mental health literacy; (5) additional areas for research; (6) delegated decision making; (7) services for court-involved individuals; and (8) involuntary commitment. These recommendations are a critical first step in this process. During the 2014 legislative interim, the Department will begin the process of implementing the recommendations contained in this report, including drafting legislation for consideration during the 2015 legislative session and referring recommendations outside of the Department's purview to the appropriate State entity.

I am grateful for the opportunity to chair this Advisory Panel. The Advisory Panel dedicated significant time to develop the recommendations contained in this report. Together, these recommendations will help improve continuity of care for individuals with serious mental illness in the state of Maryland.

Gayle Jordan-Randolph, M.D.

## Introduction

### *Charge to the Advisory Panel*

At the direction of Governor O'Malley, the Department of Health and Mental Hygiene (DHMH) convened the Continuity of Care Advisory Panel to explore ways to enhance continuity of care for individuals with serious mental illness. The Advisory Panel was charged with examining barriers to continuity of care – economic, social, legal and clinical – and making recommendations to strengthen the public behavioral health service delivery system, improve health outcomes, and address deficiencies that lead to interruptions of care.

The following state and national experts were appointed by Secretary Sharfstein to the Advisory Panel:

**1. Dr. Gayle Jordan-Randolph**, Deputy Secretary for Behavioral Health and Disabilities, will chair the Continuity of Care Advisory Panel. Dr. Jordan-Randolph is a clinically trained child psychiatrist, adult psychiatrist, and forensic psychiatrist and has extensive experience in Maryland's behavioral health system.

**2. Clarissa E. Netter**, is a senior consultant/trainer with Mainstream Recovery Consultants, a family recovery service-oriented organization. Ms. Netter has over twenty years of experience in behavioral health as both a consumer and family member. Ms. Netter has assisted in the development of self-help peer support organizations and groups, a statewide consumer leadership coalition, and special trainings on behavioral health recovery and recovery-oriented systems. Ms. Netter served as Co-chair for the social workgroup.

**3. Dr. Stephen B. Goldberg** is a Board Certified Psychiatrist and forensics expert with nearly twenty years of experience treating individuals in local jails who are awaiting trial or are serving shorter sentences before returning to the community. Dr. Goldberg is currently the Chief Operating Officer of Conmed Healthcare Management, which provides somatic, behavioral health, dental, and nursing services in a majority of Maryland jails. Dr. Goldberg served as Chair for the economic workgroup.

**4. Dr. John Boronow**, is a psychiatrist with over thirty years of experience in the treatment of patients with schizophrenia. Dr. Boronow is currently the medical director for adult services at the Sheppard Pratt Hospital and is also a Clinical Associate Professor of Psychiatry at the University of Maryland. Dr. Boronow served as Chair to the clinical workgroup.

**5. Margaret R. Garrett**, is a national and international expert on legal and regulatory health care issues. Ms. Garrett is Senior Counsel for The Johns Hopkins Health System Corporation and

is responsible for designing, implementing, and overseeing all aspects of The Johns Hopkins Health System Risk Management Program/Department. Ms. Garrett served as Co-chair to the legal workgroup.

**6. Dr. Anita Smith Everett**, is the Section Chief of Johns Hopkins Bayview Community and General Psychiatry. Her area of research is the health behavior of individuals with long-term mental illness. Dr. Everett is also on the faculty of The Johns Hopkins School of Medicine and the Bloomberg School of Public Health. Dr. Everett served as Co-chair to the social workgroup.

**7. Dr. Randell Nero**, is the Director of Patuxent Institution, a maximum security correctional facility within the Department of Public Safety and Correctional Services that provides a wide array of mental health treatment to offenders in Maryland. Dr. Nero has been a licensed psychologist since 1985 and has been working in the field of corrections for nearly thirty years. Dr. Nero served as Co-chair to the legal workgroup.

### ***Process***

The Advisory Panel held six general and public meetings from August 2013 – November 2013. DHMH also established four stakeholder workgroups to help support the broader Advisory Panel. Each workgroup examined and researched data and reports related to one of four barriers to continuity of care – economic, social, legal and clinical. The workgroups provided recommendations to the Advisory Panel about ways to better address barriers to care, prevent interruptions in treatment and improve health outcomes.

Workgroup co-chairs were selected – based on their professional background and expertise – to manage the workgroup meetings. Co-chairs were responsible for: setting the agenda for workgroup meetings; distributing materials to workgroup members for review; facilitating discussions; and working with staff to produce a final report.

Members of the public were invited to serve on the stakeholder workgroups. Each workgroup had the opportunity to present data, reports, and recommendations to the Advisory Panel. DHMH provided staff support for each workgroup. Workgroup meetings were open to the public. Meeting schedules and minutes were regularly posted on the DHMH website. Below is a brief summary of the four workgroups:

- The economic workgroup examined economic barriers that may limit access to care, such as housing, income and health coverage;
- The social workgroup examined demographic factors – race, immigration status, language, culture and gender – that may be barriers to care;

- The legal workgroup researched existing federal and state laws and regulations that impact the state's behavioral health system and provided an analysis of the laws of other states that have been enacted to improve continuity of care; and
- The clinical workgroup examined factors such as service delivery, medication, quality of care, types of evaluations and inpatient/outpatient treatment that may limit access to care.

The Advisory Panel considered the expertise and recommendations of the workgroups when developing its final recommendations.

It is important to note that the workgroups identified a number of factors that impact continuity of care but are outside of DHMH's regulatory authority; however these factors are worthy of discussion. Therefore, recommendations that need to be referred to a State entity outside of DHMH are included in **Appendix 1**. Similarly, there are areas where DHMH is already actively engaged in addressing barriers to continuity of care. The Advisory Panel supports these activities and recommends that the DHMH continue to expand these efforts which are outlined in **Appendix 2**.



## **I. ACCESSIBILITY OF MENTAL HEALTH RECORDS**

### **A. Federal and State Privacy Laws**

In Maryland, two comprehensive sets of privacy laws govern the disclosure of medical records: (1) the federal Health Insurance Portability and Accountability Act (HIPAA) and (2) Maryland's Confidentiality of Medical Records Act.<sup>1</sup> DHMH developed a comparison chart to explore similarities and differences between the Maryland Confidentiality of Medical Records Act and HIPAA. This chart serves as a starting point for comparing the two legal frameworks and includes an overview of the following categories:

- legal authority and preemption;
- coverage;
- general rules of confidentiality, uses for treatment, payment and health care operations;
- disclosures requiring authorization;
- permissive disclosures without authorization;
- mandatory disclosures;
- patient access and rights;
- patient remedies; and
- administrative procedures and forms.

This chart has not been updated since its release in 2003, and it does not include a category for mental health records. For these reasons, workgroup members indicated that additional DHMH guidance in this area is needed.

**Recommendation 1: DHMH should update information comparing federal privacy statutes and regulations with Maryland's privacy statutes and regulations, including a section devoted to mental health records. Similarly, in order to improve continuity of care, providers should encourage patients to endorse the release of patient information earlier in the evaluation process. This includes somatic and behavioral health information.**

### **B. Health Information Exchange**

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<sup>1</sup> HIPAA regulations addressing privacy of health care information, can be found at 45 CFR §§ 160 & 164, and went into effect on April 14, 2003. The Maryland's Confidentiality of Medical Records Act, codified at Health-General § 4-301 et seq., has been in effect since 1991.

The Chesapeake Regional Information System for our Patients (CRISP) is Maryland's designated health information exchange. Through this statewide health information exchange, authorized healthcare providers in Maryland and surrounding areas have access to essential patient information such as test results, lab reports, radiology reports, electronic reports, and more. Currently, behavioral health providers are not authorized participants in CRISP. Therefore, neither mental health nor substance use records can be queried by providers using CRISP. This was cited as a major barrier to continuity of care for individuals with serious mental illness.

However, it is important to note that behavioral health providers can still receive important health information through CRISP. For instance, CRISP's Encounter Notification System allows physicians, who are associated with a partnership hospital, to receive real-time alerts when a patient is hospitalized. The Encounter Notification System is provided through participating Maryland hospitals and there is no cost for ambulatory providers. Additionally, the CRISP portal is a free tool available to clinical staff that allows providers to securely look up patient information through the internet. The CRISP portal is free to physician practices.

According to the Maryland Health Care Commission's (MHCC) CRISP Monthly Report for October 2013, only a handful of mental health providers have adopted the Portal and Encounter Notification. Increased utilization of the CRISP Encounter Notification System and the Portal can improve a provider's decision making process and improve continuity of care for consumers, especially individuals with serious mental illness who may have co-occurring somatic and behavioral health conditions.

**Recommendation 2: DHMH should work collaboratively with CRISP to encourage behavioral health providers to utilize CRISP programs.**

**Recommendation 3: DHMH should ensure that there is a behavioral health representative on the CRISP Advisory Board.**

### **C. Electronic Health Record Utilization**

Electronic Health Records (EHRs) provide providers with comprehensive medical records needed to evaluate a patient's current condition in the context of the patient's health history and other treatments. EHRs also provide quick access to a patient's medical history and current medications in a crisis. Access to this data enhances a providers' decision-making and improves continuity of care. Workgroups noted that increased usage of EHRs can improve continuity of care for individuals with serious mental illness; however it is unclear if the proper incentives are in place to encourage behavioral health providers to adopt EHRs.

**Recommendation 4: Within the context of behavioral health integration, DHMH should assess active state and federal EHR incentive programs to ensure that the economic incentives are in place to encourage EHR utilization among behavioral health providers, thus improving continuity of care.**

## **II. SERVICES TO ADDRESS THE NEEDS OF INDIVIDUALS WITH SERIOUS MENTAL ILLNESS**

Care can be interrupted when there is inadequate access to needed behavioral health services. The workgroups cited a number of areas where there is a need for expanded population-specific services. These services include:

- crisis services;
- residential housing for those with serious mental illness;
- services for transitional age youth with serious mental illness;
- services for the elderly with serious mental illness;
- services for the neuropsychiatric population including those with a traumatic brain injury, epilepsy, autism and the developmentally disabled with primary mental health issues; and
- services that target individuals across various systems, including the Developmental Disabilities Administration, the Mental Hygiene Administration and the Maryland State Department of Education.

**Recommendation 5: Within the context of behavioral health integration, the Advisory Panel recommends that the DHMH continue to monitor and evaluate its ability to enhance and expand services in the areas identified above.**

## **III. WORKFORCE TRAINING**

Each of the Advisory Panel's workgroups identified deficiencies in workforce training as a barrier to continuity of care. While the State provides workforce training to health care professionals in a variety of settings, training among various disciplines must better integrate primary care and public health approaches to improve patient-centered care for individuals with serious mental illness. More specifically, the workgroups identified the need for workforce training in the following areas:

- trauma-based care and competencies; .
- discharge planning, including, but not limited to, the Residential Rehabilitation Program and the Psychiatric Rehabilitation Program;
- LGBT cultural competency; and

- cultural competency training that addresses racial/ethnic health disparities.
- Behavioral health training for language interpreters who work in health care settings was also identified as a Statewide training need.

**Recommendation 6: The Advisory Panel recommends that DHMH sponsor and conduct workforce training in the areas identified above.**

#### **IV. MENTAL HEALTH LITERACY**

The National Assessment of Adult Literacy (NAAL) measures the health literacy of adults living in the United States. Health literacy was reported using four performance levels: (1) below basic; (2) basic; (3) intermediate; and (4) proficient. According to NAAL, roughly 36 percent of adults in the United States have limited health literacy, 22 percent have basic and 14 percent have below basic health literacy. An additional 5 percent of the population is not literate in English. Ultimately, only 12 percent of the U.S. population was reported as having a proficient health literacy level.

Workgroup discussions noted that consumer health literacy plays an important role in various aspects of continuity of care. Patients are constantly required to make decisions regarding their health, including switching healthcare plans, choosing a provider, and making medication choices, all of which can have significant financial implications for the consumer and the health care system. Moreover, they must adhere to these decisions to maintain or improve health outcomes. A lack of understanding surrounding any of these areas can lead to unanticipated costs, transportation problems, missed work, child care issues, etc., thus potentially disrupting continuity of care.

Literate health consumers make better health decisions; therefore Maryland should prioritize health literacy as a component of all health care initiatives it is undertaking. The landscape of behavioral health care in Maryland is undergoing a number of changes due to DHMH's behavioral health integration efforts, as well as changes at the national and State level due to health care reform. In light of these changes, this is an opportune time to improve mental health literacy amongst consumers, family members and providers. The changes in the public behavioral health system, as well as the availability of behavioral health services through qualified health plans must be effectively communicated.

**Recommendation 7: The Department should develop mental health literacy materials and/or training that targets both consumers and providers. The development of mental health literacy materials and/or training should be done in conjunction with the Office of Minority Health and Health Disparities to ensure that materials are culturally competent.**

## **V. AREAS THAT NEED ADDITIONAL RESEARCH**

Workgroups identified several areas where additional research and interdepartmental coordination is necessary to achieve improvements in continuity of care for individuals with serious mental illness.

### **A. Addressing the Behavioral Health Provider Workforce Shortage**

Provider workforce shortage in the behavioral health area was a frequent topic in workgroup discussions. In certain areas of the state, the behavioral health provider shortage is exacerbated by a lack of primary care providers. This shortage makes it difficult for individuals with serious mental illness to receive clinically appropriate services. **Appendix 3** includes Health Professional Shortage Area maps for both mental health and primary care shortage areas.

While the Maryland Higher Education Commission and DHMH oversee various workforce incentive programs, workgroup members indicated that – to adequately address the behavioral health provider shortage in Maryland – it may be necessary to establish a discrete tuition assistance program to address this provider population. Workgroup members also noted that the behavioral health workforce shortage is further exacerbated by misaligned educational offerings with professional licensure requirements.

**Recommendation 8: DHMH should assess the need for a discrete tuition assistance program for community and behavioral health paraprofessionals (House Bill 459 of 1999).**

**Recommendation 9: DHMH should also determine whether additional workforce incentives are needed to address the behavioral health provider shortage in Maryland.**

**Recommendation 10: DHMH should work with the health professional boards to align professional licensing requirements with educational offerings.**

### **B. Expansion of Telemedicine**

According to MHCC, recent data collected from Maryland physicians indicate that approximately 11.5 percent of physicians are using telemedicine for purposes of diagnosis, second opinion, follow-up, chronic disease and emergency care, among others. Ad-hoc discussions with various office-based physicians regarding telemedicine adoption identified several areas of concern including the lack of confidence with the technology, a lack of understanding about reimbursement opportunities, liability concerns and the limited nature of the reimbursement opportunities that do exist (such as the geographic restriction on the patient

location for Medicare patients and more prevalent restrictions on reimbursement for care delivered to a patient in his or her home.

Workgroups agreed that telemedicine can bridge the gaps of distance and health care disparity. This is especially important when it comes to caring for individuals with serious mental illness due to the shortage of mental health care providers in the state. The workgroups noted that both providers and consumers can benefit from telemedicine. Telemedicine allows consumers to experience expanded access to providers, more convenient treatment, reduction of lost work time and travel costs, and ensures better continuity of care. Economic barriers include current uncertainty about liability, reimbursement and economic barriers to access the technology for both consumers and providers.

**Recommendation 11: DHMH should continue to assess State policies that embrace the expansion of telemedicine in both urban and rural communities, including ways to incentivize the use of telemedicine for mental health services to address the behavioral health professional provider shortage.**

### **C. Addressing Language Barriers in Health Care Settings**

Workgroups also cited language as a barrier to continuity of care. While each healthcare provider who receives federal funds must provide meaningful language access, states do not have to reimburse providers for these expenses. It was noted that this could be addressed by including language services as a reimbursable service under the State's Medicaid Plan. In 2000, the Centers for Medicare and Medicaid Services reminded states that they could obtain federal matching funds for language services provided to Medicaid or Maryland Children's Health Insurance Program (CHIP) enrollees. More specifically, "federal matching funds are available for states' expenditures related to the provision of oral and written translation administrative activities and services provided for CHIP or Medicaid recipients. Federal financial participation is available in state expenditures for such activities or services whether provided by staff interpreters, contract interpreters, or through a telephone service."

**Recommendation 12: DHMH should assess whether there is a need to include language services as an administrative or optional covered service in Maryland's Medicaid Program and the Maryland Children's Health Insurance Program.**

### **D. Additional Areas for Future Research**

The Economic, Social, Legal and Clinical workgroups cited several areas that warrant further study including:

- ways to enhance readily available clinical data reports about Medicaid patients;
- ways to expand effective pilot programs;
- ways to integrate clinical data sharing and access across all levels of care;
- the expansion of mental health courts in Maryland;
- the ability to reimburse programs utilizing certified non-licensed professionals, board approved trainees, paraprofessionals and peer-specialists under supervision of licensed professionals;
- the development of fee-for-service CPT codes and fee schedules to allow outpatient providers to physically meet (and build connections) with consumers on inpatient units, prior to discharge; provide non-face-to-face coordination of care and case management services; and allow Medicaid billing for collaborative care meetings between behavioral health and somatic practitioners such as implemented by the Cherokee Health Systems in Tennessee;
- barriers to continuity of care.;
- identification of regional disparities in services to the seriously mentally ill;
- evaluation of reimbursement requirements and rates for all behavioral health professional categories, including mental health, substance use disorder, and other categories of providers, including whether rates should be adjusted;
- the feasibility of requiring commercial insurance carriers to identify individuals with serious mental illness who are high-end utilizers of care and create an additional level of intensive services for this group of individuals; and
- the State's ability to optimize alignment of payers for the seriously mentally ill.

**Recommendation 13: As the department moves forward with behavioral health integration and health care reform, it should consider researching topics in the areas identified above.**

## **VI. DELEGATED DECISIONMAKING**

### **A. Surrogates**

The Advisory Panel identified numerous barriers to continuity of care for individuals with serious mental illness that can be resolved through changes to Maryland's Health Care Decisions Act. When an individual is incapacitated due to illness, disease, mental illness, or a developmental disability, other individuals may need to make medical decisions for them. The Health Care Decisions Act permits family and friends to make medical decisions for an individual who is unable to make decisions for him or herself.

Medical decision making can occur through several avenues. After two doctors certify that a patient is unable to make decisions about their healthcare, the doctors will ask whether the patient has named a healthcare agent in a health care advance directive. If there is no appointed

agent, the doctors will look to the closest relative or friend to make health care decisions. This person is called a surrogate. Surrogates may act in the following order of priority: (1) a legally appointed guardian (2) a spouse (3) an adult child (4) a parent (5) an adult sibling and (6) a close relative or friend.

Under current law, a surrogate is expressly prohibited from authorizing treatment for a mental disorder. Surrogates can however, authorize treatment for somatic health issues even when the symptoms resemble those associated with mental illness. This disparate treatment of somatic health and mental health issues was cited by the Advisory Panel as a significant barrier to continuity of care for individuals with a serious mental illness.

**Recommendation 14: Amend the Health Care Decisions Act to allow a surrogate to authorize the treatment of a mental disorder.**

## **B. Guardianship**

As noted above, a legal guardian receives the highest order of priority as a surrogate. Under current law, a legal guardian may be appointed by the court if the court determines that a person lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person – including provisions for health care, food, clothing, or shelter – because of any mental disability, disease, habitual drunkenness, or addiction to drugs. Guardians can only be appointed if the court finds that no less restrictive form of intervention is available which is consistent with a person’s welfare or safety.

Once appointed, a guardian is obligated to file an annual report with the court. The report is meant to supervise the guardian’s actions and to determine whether the guardianship should be modified or terminated.

The Advisory Panel raised concerns that the existing process for supervising and annually reviewing a guardian’s actions fails to meet the unique needs of individuals with serious mental illness who experience brief periods of incompetency. In these cases, short-term or temporary guardianship may be more appropriate because they would provide for court review in shorter intervals. As an individual regains competency, the guardianship can be terminated by the court.

**Recommendation 15: Statute should be amended to allow for short term or temporary guardianship. Guardianship would be reevaluated after six months (in comparison to the annual evaluation) to account for instances when individuals are experiencing brief instances of psychosis.**



**Recommendation 16: DHMH should provide additional education to patients, consumers and other relevant parties on what is covered by guardianship.**

### **C. Advance Directive for Mental Health**

Individuals who need mental health services, who may become incapacitated in the future or who have intermittent competency, may choose to designate a health care agent to ensure that they receive specified mental health services even when they are no longer able to consent to the provision of services themselves. This can be achieved through the execution of an advance directive for mental health services.

An advance directive for mental health services may include: (1) the designation of an agent to make mental health services decisions for an individual; (2) the identification of mental health professionals and facilities that the individual would prefer to provide him/her with mental health services; (3) a statement of medications preferred by the individual for psychiatric treatment; and (4) instruction regarding the notification of third parties and the release of information to third parties about mental health services provided to the individual.

The Advisory Panel is concerned that there are instances when advance directives are not implemented due to statements an individual may make when they are incompetent. For instance, despite the execution of an advance directive for mental health treatment, individuals have the right to revoke their advance directive at any time, even when they are incapacitated and in need of treatment. Therefore, an advance directive for mental health that is developed when an individual is competent may never be honored if that individual chooses to revoke an advance directive when they are incompetent.

**Recommendation 17: Amend statute to create a delay in terms of revoking an Advance Directive for Mental Health Treatment so that revocation does not take effect until 72 hours after the request to revoke is made.**

**Recommendation 18: Provide educational training on Advance Directives to providers, consumers and family members.**

**Recommendation 19: Evaluate the impact of eliminating the Advance Directive Registry Fee for those who cannot afford it.**

**Recommendation 20: Further study the potential need to amend Maryland Health-General Code Ann. § 10-632 to allow for a determination by an Administrative Law Judge as to whether or not someone has the capacity to sign voluntarily to be admitted to a facility for**

**psychiatric treatment so that individuals under guardianship who are competent do not lose their civil rights.**

## **VII. SERVICES FOR COURT-INVOLVED INDIVIDUALS**

### **A. Clinical Review Panels**

In 2005, the Bureau of Justice Statistics noted that half of all prison and jail inmates had a mental health problem. With the exception of a life-threatening crisis, the Department of Public Safety and Correctional Services (DPSCS) lacks the statutory authority to administer psychotropic medications over an inmate's objection. In order to administer a psychotropic medication to an inmate, over his/her objection, the inmate must be transferred to a State psychiatric hospital where a clinical review panel determines whether to administer medication over objection.<sup>2</sup>

The Advisory Panel identified two areas of concern related to the existing clinical review process in Maryland. First, without admission to a State psychiatric hospital, there is no process for providing non-emergency involuntary treatment. Inmates who do not meet the admission criteria for State hospitalization cannot be admitted to these facilities. Second, clinical review panel decisions cannot be applied outside of State hospitals. Thus, even if an inmate has been treated and stabilized in a State hospital, all involuntary medication must be discontinued once an inmate is returned to a DPSCS institution.

These same issues have also been identified by the legislature. The 2013 Joint Chairmen's Report required the DPSCS to submit a study of the use of non-emergency involuntary medication of inmates in DPSCS custody. Among other things, DPSCS indicated that the number of inmates and detainees who would benefit from medication over objection fluctuates with inmate acuity, but typically ranges between 10 and 20 inmates. Although there is a small subset of inmates who would directly benefit from involuntary medication, their untreated mental illness has profound negative effects on the inmates themselves, their peers and the staff charged with their safekeeping and treatment. Inmate quality of life, functioning level,

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<sup>2</sup> Pursuant to the Health-General Article § 10-708 a clinical review panel is authorized to approve the administration of medication to (and approval of alternative medications for) an individual who objects to the medication if the panel determines that (1) the medication is prescribed by a psychiatrist for the purpose of treating the individual's mental disorder; (2) the administration of medication represents a reasonable exercise of professional judgment; and (3) without medication, the individual is at substantial risk of continued hospitalization. Moreover, the individual must be at substantial risk of continued hospitalization due to (1) remaining seriously mentally ill with no significant relief from, or for a longer period of time with, the mental illness symptoms that cause the individual to be a danger to the individual or to others or (2) relapsing into a condition in which the individual is in danger of serious physical harm resulting from the individual's essential human needs of health or safety.

mental status and medical conditions all deteriorate. Among these inmates, medication noncompliance has been linked to suicide attempts, severe self-mutilation, head-banging and assaults on staff and peers.

The Advisory Panel believes that these concerns could be addressed by extending clinical review panel decisions made at a DHMH facility so that once an inmate is returned to a DPSCS institution, involuntary medication could still be continued for a specified period of time.

**Recommendation 21: Pilot the expansion of clinical review panels to extend clinical review panel decisions rendered by DHMH to individuals within the custody of DPSCS. DHMH should work in conjunction with the DPSCS to implement a pilot program.**

## **B. Community-Based Forensic Services**

The Office of Forensic Services at DHMH oversees services provided for individuals with mental illnesses who are court-involved. Among other things, these services include the monitoring of individuals found not criminally responsible and court-ordered to conditional release in the community through the Community Forensic Aftercare Program. If an individual violates a conditional release order, the court will issue a hospital warrant. This warrant authorizes any law enforcement officer in the State to apprehend and transport that individual to a facility designated by DHMH. In many cases, this leads to readmissions to State hospitals that may not be clinically appropriate.

Current data indicates that the number of individuals conditionally released to the Community Forensic Aftercare Program has increased significantly from 31 in 2008 to 146 in 2013. Over the same time period, the number of hospital warrants issued has fluctuated, indicating that the current level of forensic monitoring may not be sufficient to support appropriate and successful transitions into the community.

**Recommendation 22: Readmissions to state hospitals can be further prevented if additional aftercare services are available to assist in an individual's transition back into the community. DHMH should evaluate the cost of expanding forensic aftercare services and implement a pilot community based forensic program.**

## **VIII. INVOLUNTARY COMMITMENT**

**Appendix 4** includes a history of involuntary commitment and additional context for the foundation of involuntary commitment law in Maryland. Under current law, a health care facility or Veterans' Administration hospital may not involuntarily admit an individual unless (1) the individual presents a danger to the life or safety of the individual or of others; (2) the individual

has a mental disorder and needs inpatient care or treatment; (3) the individual is unable or unwilling to be admitted voluntarily; (4) there is no available, less restrictive form of intervention that is consistent with the welfare and the safety of the individual; and (5) if the individual is 65 years old or older and is to be admitted to a State facility, the individual has been evaluated by a geriatric evaluation team, and no less restrictive form of care or treatment was determined by the team to be appropriate.

It is important to note that specific due process protections exist for individuals who are involuntarily committed. Health-General §10-631 requires that the committed person be notified of his rights, including his right to counsel, while §10-632 provides for the committed person to receive notification of his right to a hearing within 10 days of admission, when that hearing will be and other attendant rights and restrictions. In Maryland, civil commitment hearings are administrative rather than judicial, so there is no right to a trial by jury in routine civil commitment proceedings. Further due process protections in Maryland relate to the right to limited judicial review (Health-General §10-633), the right to file *habeas corpus* petitions (§10-804), and the right to file for judicial release annually (§10-805). Unlike the administrative civil commitment hearings, a committed person filing for judicial release under §10-805 does have the right to request a trial by civil jury. Moreover, Code of Maryland Regulations limits the length of time for a single civil commitment to 6 months.<sup>3</sup>

### **A. Dangerousness Standard**

Workgroup members noted that in practice, there is variance in how the “dangerousness” standard is interpreted across the healthcare system. This has led to inconsistent application of the dangerousness standard in various settings, including emergency evaluations.

Similarly, issues surrounding involuntary admissions and the dangerousness standard have been identified by the legislature. House Bill 1258/Senate Bill 1040 of 2013 would have established a “gravely disabled” standard and would have allowed for involuntary admission in instances when an individual was deemed gravely disabled. In accordance with the aforementioned bills, gravely disabled means that an individual is incapable of making an informed decision and has behaved in a manner indicating that the individual is unlikely – without the supervision and assistance of others – to satisfy the individual’s needs for nourishment, personal or medical care, shelter, or self-protection and safety. It is important to note that Senate Bill 1040 was amended to eliminate a separate gravely disabled standard and to provide a definition of the current “danger to self” standard that includes those who would be considered gravely disabled.

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<sup>3</sup> COMAR 10.21.01.08 (C) (1)

The Advisory Panel does not believe that a gravely disabled standard will address inconsistencies in involuntary admission practices. Rather, the Panel asserts that dangerousness to self is included in the civil commitment criteria; variances in involuntary admissions are the result of other factors, including the application and interpretation of “dangerousness to self,” failure of the State to define dangerousness, and inadequate provider training.

**Recommendation 23: DHMH should promulgate regulations defining dangerousness to promote consistent application of this standard throughout the health care system.**

**Recommendation 24: To further ensure consistency, DHMH should develop and implement a training program for health care professionals regarding the dangerousness standard as it relates to conducting emergency evaluations and treatment of individuals in crisis. Training should also be extended beyond the emergency room to Administrative Law Judges, the Office of the Public Defender, consumers and family members to ensure consistent application of the standard statewide.**

## **B. Outpatient Civil Commitment**

At the direction of the Advisory Panel, each workgroup discussed involuntary civil commitment, including involuntary commitment in outpatient setting. The workgroups were, however, unable to reach a consensus on this topic. To further assist the Advisory Panel with their deliberations, the Department contracted with an independent consultant to provide an analysis of the origin of outpatient civil commitment, a review of outpatient civil commitment research and options to outpatient civil commitment. The report – *Involuntary Outpatient Commitment: Current Evidence and Options* – can be viewed at <http://dhmh.maryland.gov/bhd/SitePages/CCAP.aspx>. The advisory panel supports the report’s finding that there is evidence of the effectiveness of a well-designed outpatient civil commitment program and recommends moving forward to define such a program in Maryland.

**Recommendation 25: The Secretary of DHMH should convene a workgroup to further examine the implementation of an outpatient civil commitment program in Maryland. As part of this process, the workgroup should develop a proposal for an outpatient civil commitment program that: (1) respects civil liberties of individuals to be served; (2) addresses the potential for racial bias and health disparities in program implementation; (3) is based on evidence of effectiveness, and include a data monitoring strategy; (4) proposes how to promote parity between public and private insurers; (5) addresses the potential for variance in program implementation among urban and rural jurisdictions; and (6) assesses the cost to DHMH and other state agencies, including the feasibility of securing Federal Financial Participation for services provided through the program.**



## **Appendix 1 – Recommendations to Refer to Other State Entities**

The Advisory Panel recommends that the following recommendations be referred to the appropriate State entity:

- Expand Housing First statewide.
- Update vulnerability index for Housing First applicants to better capture the seriously mentally ill population.
- Standardize admission and termination procedures statewide for public housing and Section 8, etc.
- Standardize admission and termination procedures from emergency shelters.
- Initiate a comprehensive study of different models of housing programs in Maryland and continue to examine housing as a social barrier to continuity of care.
- Adopt legislation that prohibits discriminatory practices in the sale or rental of housing because of a person's source of income, including any government or housing assistance (Senate Bill 487 of 2013).
- In the absence of safe and affordable permanent housing, encourage the expansion of "safe havens."
- Establish additional LGBT Health Centers.
- Assure bus passes/vouchers allow minor children to accompany adults to medical appointments without additional costs
- Behavioral health stakeholder involvement in the Maryland Transit Administration's Citizen Advisory Committee for Accessible Transportation and other applicable transportation advisory groups.

Similarly, the recommendations below should be referred to the Maryland Insurance Administration:

- Once the Affordable Care Act is fully implemented, the Maryland Insurance Administration should consider exploring legal or legislative remedies to address the refusal of commercial insurance companies to honor their parity obligations to provide crisis residential housing as part of their benefit package.
- DHMH, the Maryland Health Benefit Exchange (MHBE), and the Maryland Insurance Administration (MIA) should assess the effectiveness of the continuity of care provisions included in the Maryland Health Progress Act of 2013 post 2015 and propose necessary modifications. This assessment should include data collected through MHBE, MIA, and the MHBE Standing Consumer Advisory Committee to provide input on consumer experience with these provisions.

- DHMH should encourage MIA to undertake proactive periodic reviews of insurers' proposed networks. If the current complaint process remains in place, MIA should consider enhancing its visibility to make it easier for individuals to lodge complaints, including requiring insurers to list the MIA number on the provider directories. DHMH should work with MIA to facilitate this process.



## **Appendix 2 - Existing DHMH Programs and Efforts**

The Economic, Social, Legal and Clinical workgroups of the Advisory Panel cited several areas where the DHMH should promote and expand current efforts to facilitate improvements to continuity of care. The Advisory Panel supports the expansion and promotion of:

- existing Loan Assistance Repayment Programs within the behavioral health provider community and efforts to address workforce shortages in underserved areas;
- the Health Systems and Infrastructure's Administration's efforts to provide Planning for Access to local jurisdictions;
- engaging primary care providers to focus on treating individuals with less severe mental health issues, to allow behavioral health practitioners to focus on treating those with serious mental illness;
- models of care that support flexible hours (evening and weekend) for consumers of the mental health system, including Patient Centered Medical Homes;
- rapid Medicaid enrollment;
- enrolling those who are incarcerated in Medicaid or a qualified health plan;
- LGBT data analysis, the promotion of LGBT local health disparities programs, LGBT outreach activities, LGBT cultural competency and health literacy training; and
- meaningful consumer satisfaction surveys for the public behavioral health system.

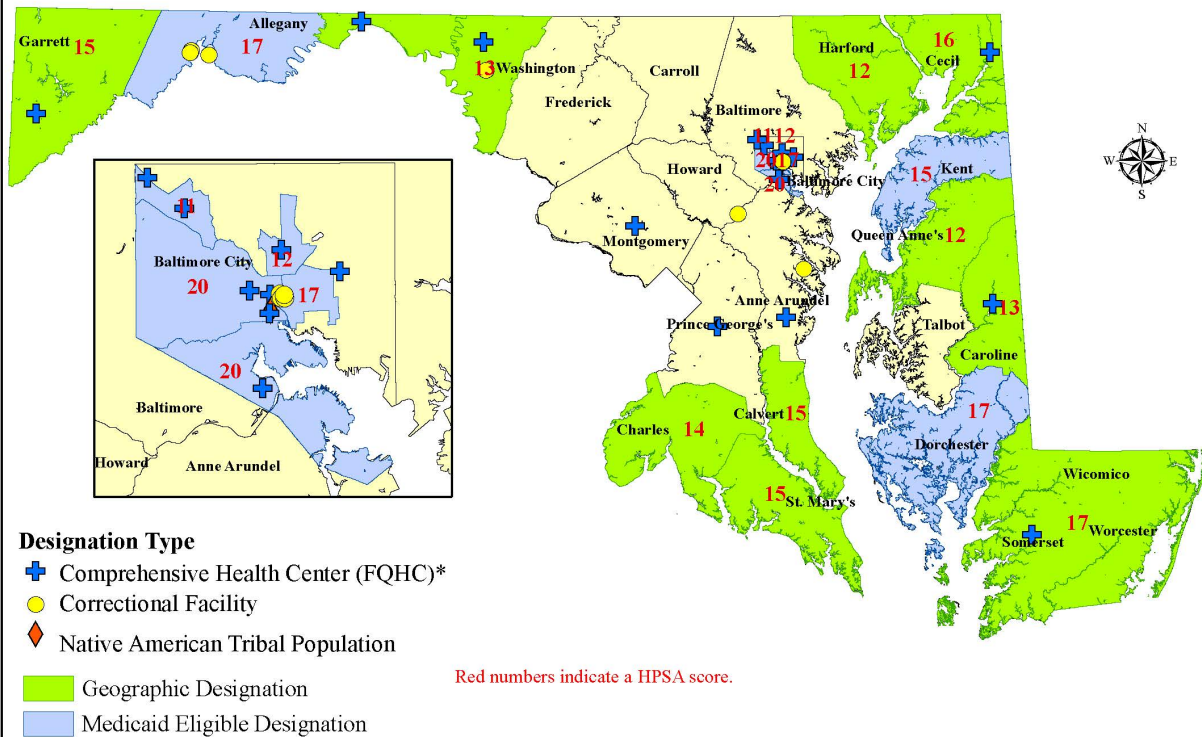
### **Appendix 3 – Health Professional Shortage Areas**

Health Professional Shortage Areas (HPSA) are designated by the federal Health Resources and Service Administration as having acute shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility). An area receiving a HPSA designation is assigned a score that ranges from 1 to 25 for primary care and mental health. HPSA scores are developed for use by the National Health Services Corps in determining priorities for assigning physicians. A higher HPSA score indicates greater priority.

HPSAs are eligible for more than 30 federal program resources and benefits, including various the J1 Visa Waiver Program, the National Health Services Corps, Loan Assistance Repayment Program, and enhanced Medicare and Medicaid reimbursement.

For additional information on Health Professional Shortage Areas, visit <http://hsia.dhmdh.maryland.gov/opca/SitePages/pco-shortage.aspx>.

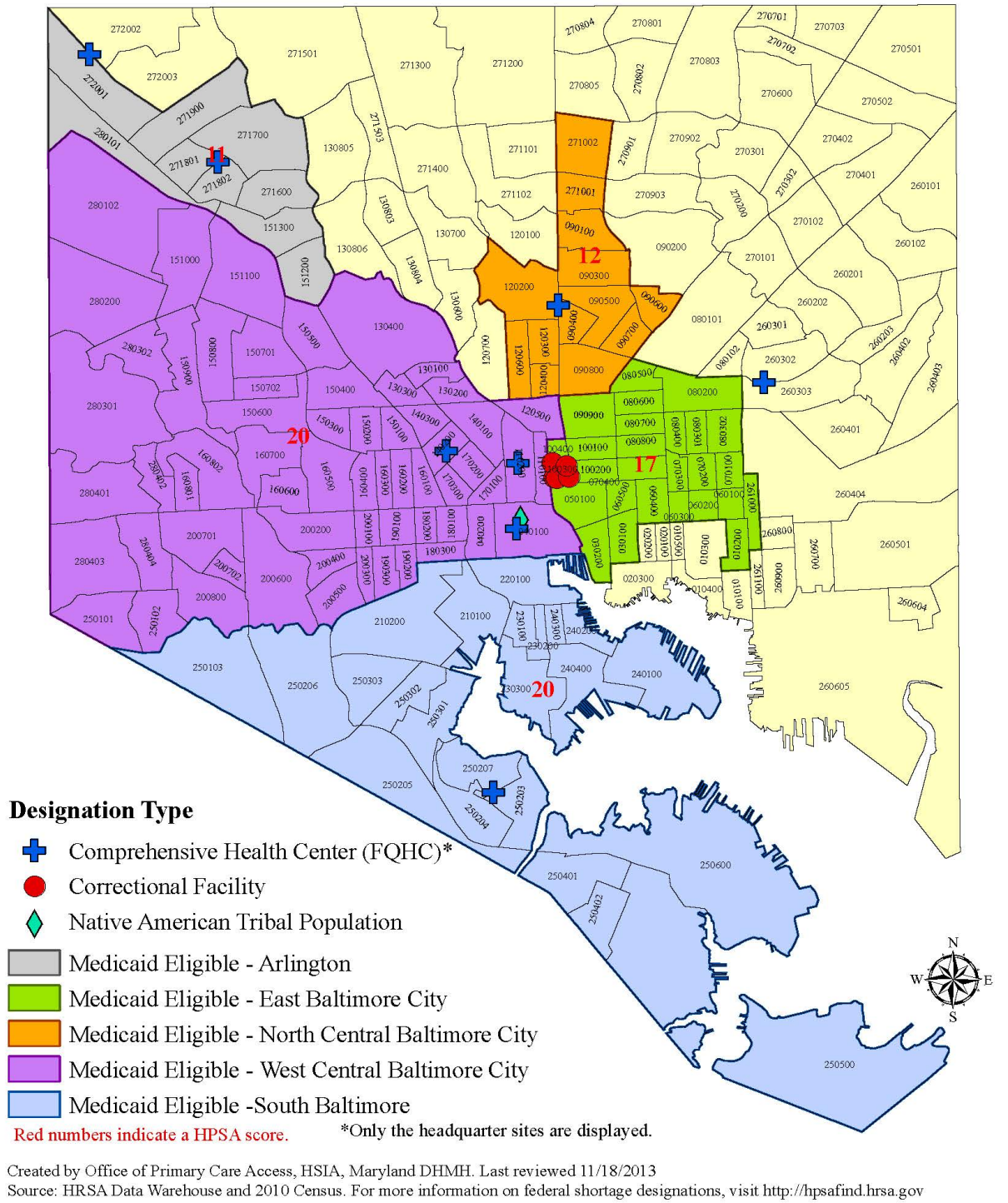
## Maryland Health Professional Shortage Area (HPSA) Designations for Mental Health as of 11/18/2013



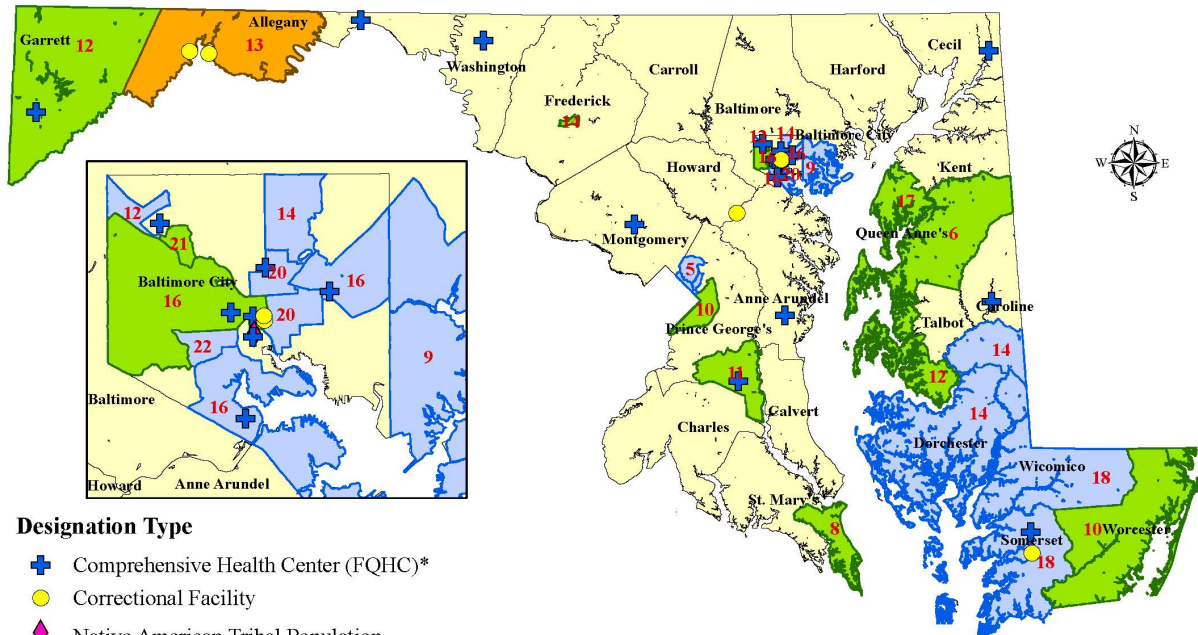
\*Only the headquarter sites are displayed.

Created by Office of Primary Care Access, HSIA, Maryland DHMH. Last reviewed 11/18/2013  
Source: HPSA Data Warehouse and 2010 Census. For more information on federal shortage designations, visit <http://hpsafind.hrsa.gov>

# Baltimore City Health Professional Shortage Area (HPSA) Designations for Mental Health as of 11/18/2013



## Maryland Health Professional Shortage Area (HPSA) Designations for Primary Care as of 11/18/2013



### Designation Type

- ⊕ Comprehensive Health Center (FQHC)\*
- Correctional Facility
- ◆ Native American Tribal Population
- Geographic Designation
- Low Income Designation
- Medicaid Eligible Designation

Red numbers indicate a HPSA score.

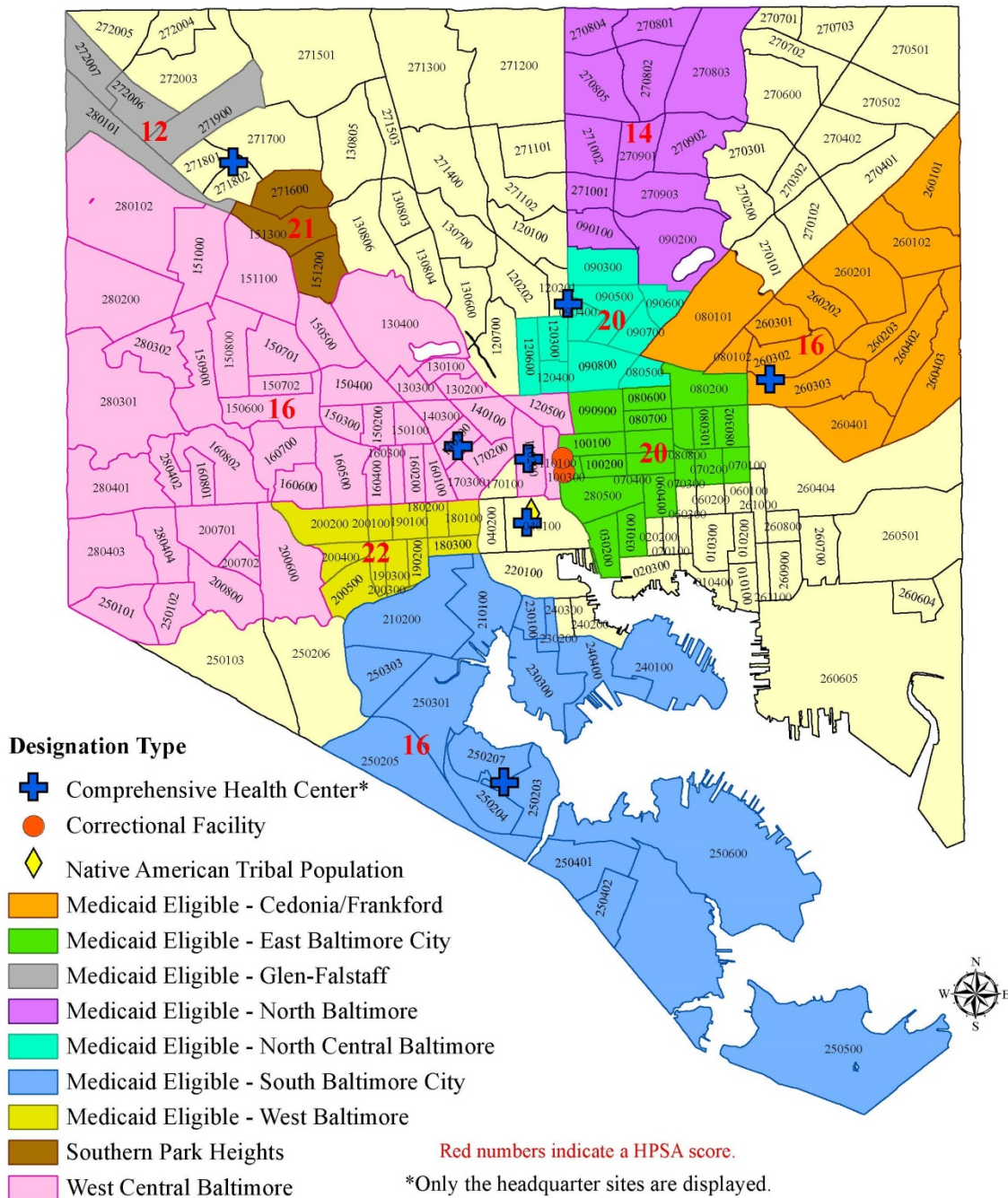
\*Only the headquarter sites are displayed.

Created by Office of Primary Care Access, HSA, Maryland DHMH. Last reviewed 11/18/2013

Source: HRSA Data Warehouse and 2010 Census For more information on federal shortage designations, visit <http://hpsafind.hrsa.gov>



## Baltimore City Health Professional Shortage Area (HPSA) Designations for Primary Care as of 11/18/2013



Created by Office of Primary Care Access, HSIA, Maryland DHMH. Last reviewed 11/18/2013  
Source: HRSA Data Warehouse, 2010 Census. For more information on federal shortage designations, visit <http://hpsafind.hrsa.gov>

## Appendix 4 - History of Involuntary Civil Commitment

Civil commitment law is based on the two complementary principles: (1) *parens patriae* and (2) police power. *Parens patriae*, or “parent of the country,” is when a person is unable to care for himself, and it is the obligation of the government to provide assistance and support and to care for him. In comparison to *parens patriae*, police power is more restricted and indicates that when a person is a threat to himself or to others, it is the obligation of the government to protect himself and others from his threatening behaviors/actions.

Early civil commitment law was developed under a *parens patriae* approach. Stemming from the English common law, the *parens patriae* doctrine provides the government with the authority to care for those unable to care for themselves due to their being incapacitated by mental illness or other mental impairment. In the mid-1800s, doctors were able to admit patients with mental disorders to the expanding asylum-based system on a determination that the person was in need of institutional care, with little in the way of procedural protections. For example, when Illinois opened its first state psychiatric hospital in 1851, a statute was passed that required a public hearing on whether a person should be committed, but the criteria for admission were ill-defined, and there was an exception allowing a husband to commit his wife without any hearing.

In 1860, Mrs. Elizabeth Packard was committed to an asylum in Illinois after she began to voice religious disagreements with her husband. Mrs. Packard contested her institutionalization, winning her release after three years of institutionalization. This led to the passage of a revised statute in 1865 requiring a jury trial for civil commitment in Illinois, but the jury was only required to make a finding as to the defendant’s mental state, without reference to any specific standard. By 1900, states generally had laws requiring some form of judicial review before a person could be committed to a psychiatric hospital, again, without reference to any criteria for admission other than a “need for care” or a “need for treatment.” Over half a million people were in state psychiatric hospitals across the US by 1950.

Beginning in the 1960s, there was a series of landmark cases setting out limits on the involuntary treatment of people suffering with mental illness. In Maryland, the statutory language was adopted that permitted civil commitment only when “[t]here is no available, less restrictive form of intervention that is consistent with the welfare and safety of the individual” (Health-General §10-617).

In 1969, California passed the Lanterman-Petris-Short, or LPS act. This law introduced the requirement that a person must meet dangerousness-based criteria or grave disability criteria in order to be admitted involuntarily. This marks the ascendance of the police power theory of civil commitment, which posits that the governmental authority for civil commitment stems from

the state's role in protecting citizens from their fellows with mental illness, a more restrictive and liberty-based approach than the *parens patriae* philosophy. Maryland's statute requires a showing that the committed person "presents a danger to the life or safety of himself or others" (Health-General §10-617). As mentioned previously, Maryland's statute does not include a provision for the gravely disabled.

The police power approach to civil commitment was further operationalized in *Lessard v Schmidt*, a 1972 case decided by the US District Court for the Eastern District of Wisconsin. In this case, the court established the requirement that the state demonstrate that the committed person engaged in a "recent overt [dangerous] act" in the time period prior to the commitment. In addition, the case began to set out due process protections attendant to the civil commitment process, including the notification to the committed person of the right to a trial by jury and the right to be represented by counsel. Finally, the case established, in Wisconsin, the principle that the state must prove its case beyond reasonable doubt, the standard of proof generally applied in criminal cases. Maryland adopted only some of these due process protections. Health-General §10-631 requires that the committed person be notified of his rights, including his right to counsel, while §10-632 provides for the committed person to receive notification of his right to a hearing within 10 days of admission, when that hearing will be, and other attendant rights and restrictions. In Maryland, civil commitment hearings are administrative rather than judicial, so there is no right to a trial by jury in routine civil commitment proceedings. Further due process protections in Maryland relate to the right to limited judicial review (Health-General §10-633), the right to file *habeas corpus* petitions (§10-804), and the right to file for judicial release annually (§10-805). Unlike the administrative civil commitment hearings, a committed person filing for judicial release under §10-805 does have the right to request a trial by civil jury.

In the 1975 case *O'Connor v Donaldson*, the US Supreme Court ruled that "a State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." Scholars have debated the meaning of the term "more" since that time, and there have been no clarifying decisions since 1975. Some view the "more" as implying that the confinement must come with treatment else it be considered akin to imprisonment, but most view this decision as making the commitment contingent on a showing of dangerousness or other inability to survive safely in the community. Thus, this case extends the *Lake v Cameron* requirement to consider less restrictive alternatives to the entire US, and it further bases civil commitment on a police power ideology. In 1977, the Connecticut state Supreme Court decided the case *Fasulo v Arafteh*, requiring periodic review of long-term civil commitment, and required that the state prove its case by the lower standard of clear and convincing evidence. At this time, some states, including Texas, required a showing only that a person was appropriate for involuntary admission by the lowest legal standard, preponderance of the evidence. Maryland



adopted this requirement by limiting the length of time for a single civil commitment to 6 months (COMAR 10.21.01.08(C)(1))

The differential standards of proof were addressed in 1979 in *Addington v Texas*. Here, the US Supreme Court established clear and convincing evidence as the minimum standard by which a person could be involuntarily admitted for psychiatric treatment. Preponderance of the evidence is the standard for most civil trials, where only property is at issue. Liberty is viewed as a higher constitutional interest, and the highest standard, beyond a reasonable doubt, is required in a criminal trial to remove the person to prison, thus taking his liberty. Clear and convincing evidence is a medium standard, falling between the other two standards, and is used where something other than property is being taken from the defendant or respondent, such as custody cases.

In *Addington*, the Court noted that “it is indisputable that involuntary commitment to a mental hospital after a finding of probably dangerousness to self or others can engender adverse social consequences to the individual. Whether we label this phenomena ‘stigma’ or choose to call it something else is less important than that we recognize that it can occur and that it can have a very significant impact on the individual.” Thus, the Court acknowledged that the person being civilly committed is suffering not only a liberty infringement but also other adverse outcomes commonly labeled “stigma.” However, the Court also noted that the committed person suffers when treatment is not provided, in that “[o]ne who is suffering from a debilitating mental illness and in need of treatment is neither wholly at liberty nor free of stigma.” Thus, there is balance of adverse consequences not attendant to the convicted criminal, and the court concluded that the standard of proof may be less than that required for liberty losses not counterbalanced by this exchange, such as incarceration after conviction for a crime.

In addition, the court noted that medical (and psychological) opinions are stated with “reasonable medical [psychological] certainty,” and often such opinions may not reach the reasonable doubt standard. States are free to require the higher, reasonable doubt, standard, but Maryland has adopted the medium, clear and convincing standard of proof for civil commitment cases (Health-General §10-632).

## **Present State of Civil Commitment**

At present, civil commitment requires attention not only to the presence of an illness in need of treatment but to some acute, present risk of harm to the person or to others based in the untreated or inadequately treated mental illness. Thus, the current paradigm is police power, wherein the government may intervene only when there is a risk of harm, and not only in response to a need for treatment. There are numerous protections in law against civil commitment, including defined risk-based criteria and various due process safeguards, such that

only those whose mental illness causes them to be likely to harm may be subject to civil commitment.

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